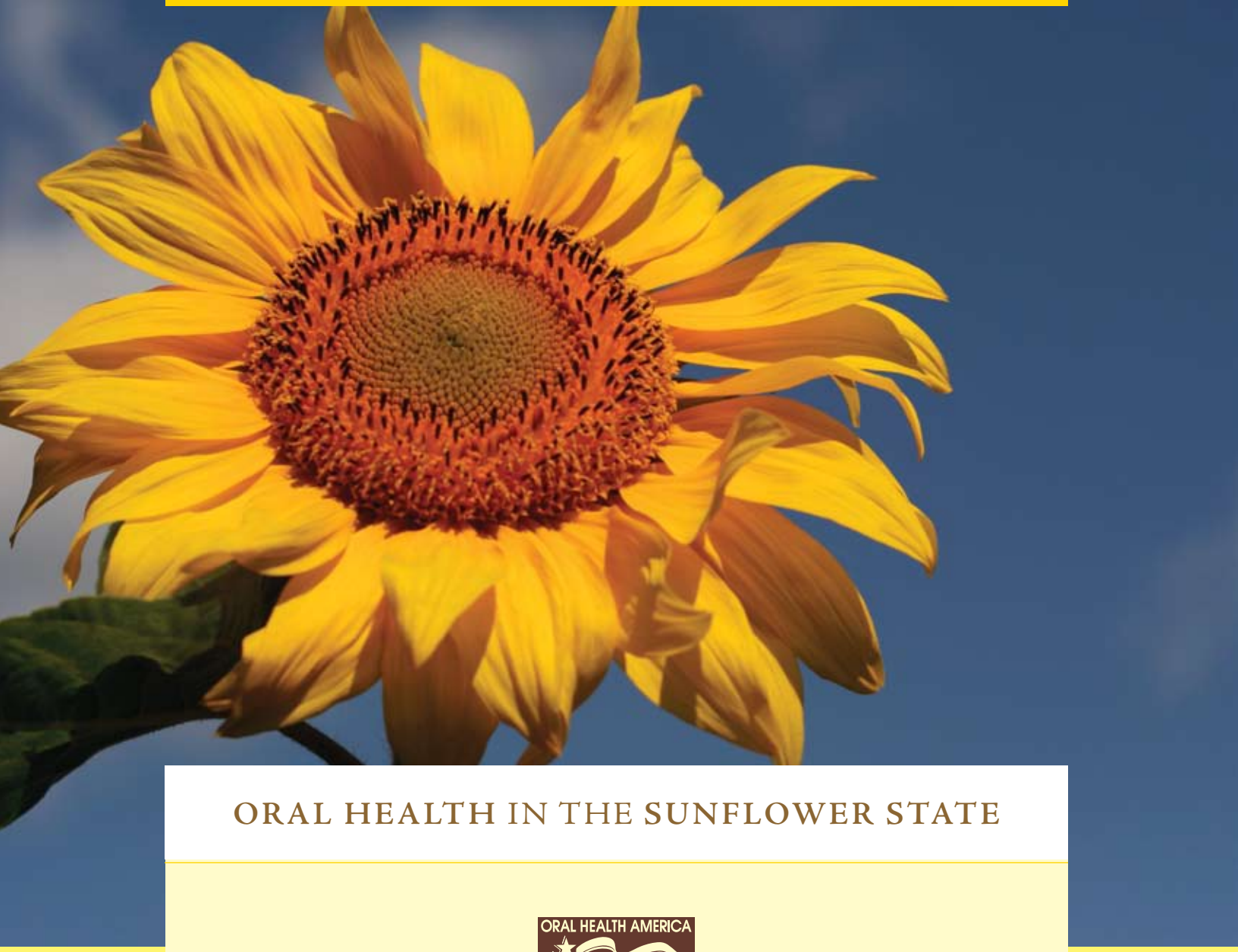
KANSAS ORAL HEALTH GRADING PROJECT 2009

Keep Kansas Smiling

STATE GRADE: B

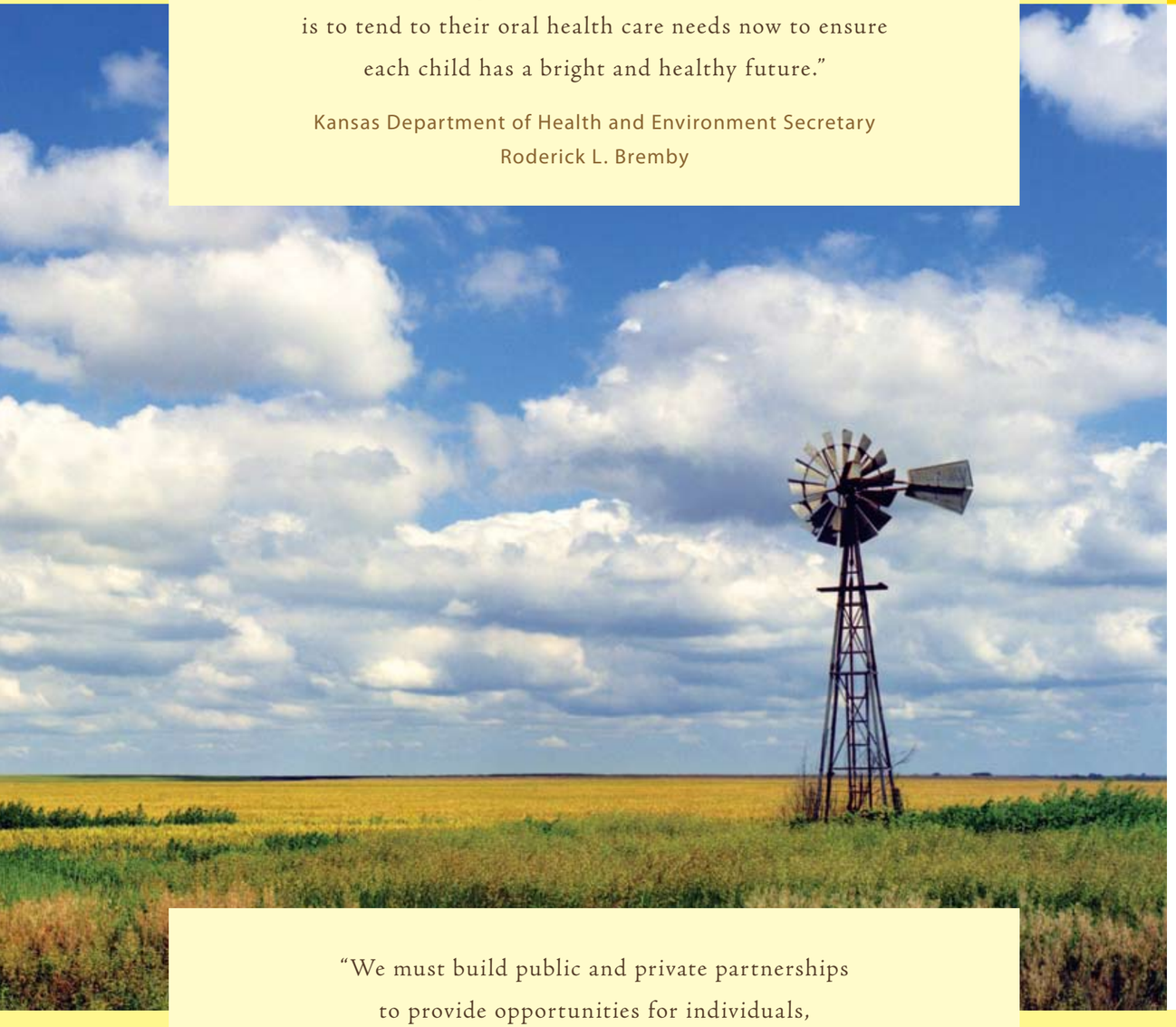


ORAL HEALTH IN THE SUNFLOWER STATE

ORAL HEALTH AMERICA
LEADING THE WAY TO A HEALTHY FUTURE
Campaign for Oral Health Parity

"Oral health problems in children are a precursor for more serious health problems as children reach adulthood. One of the best things we can do for the health of our children is to tend to their oral health care needs now to ensure each child has a bright and healthy future."

Kansas Department of Health and Environment Secretary
Roderick L. Bremby



"We must build public and private partnerships to provide opportunities for individuals, communities and health professionals to work together and improve the nation's oral health."

David Satcher, MD, PhD,
16th Surgeon General of the United States

Table of Contents

This report card provides a snapshot of oral health in Kansas. The grading categories are intended to call greater policy attention to oral disease prevention, access to care, infrastructure, health status, and oral health related laws. The report card is not intended to grade any specific program, but instead look at the many factors that contribute to good oral health and successful oral health care systems.

Keep Kansas Smiling

2009 Oral Health Report Card

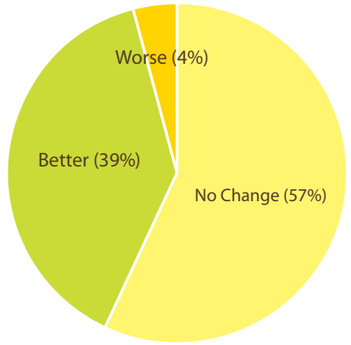
Grader Comments

In the years since Oral Health America's 2003 oral health report card, *Keep America Smiling*, Kansas made significant progress in addressing oral disease, resulting in an overall grade improvement from a "D+" in 2003 to a "B" in 2009.

At the heart of the United States, Kansas is a leader in making oral health a priority. The Kansas Department of Health and Environment's Office of Oral Health hired a state dental director in 2006. Oral Health Kansas, the state's five-year-old oral health coalition, has broad representation from civic institutions and the healthcare sector, and is a model for other states in connecting leaders, leveraging resources, developing partnerships, and promoting oral health advocacy, public awareness and education.

Overall Grade	**B**
Prevention	C
Access to Care	D-
Oral Health Infrastructure	B+
Health Status	C+
State Policies	D
Extra Credit	**A**

GRADE COMPARISON: 2003 - 2008



Yet significant challenges remain. Kansas must follow through on the ambitious goals set forth in the new Kansas Oral Health Plan [2] in order to increase dental care options and disease prevention services, address complex dental workforce issues, and strengthen policies that improve oral and overall health. In doing so, Kansas will demonstrate success to many other states that share its challenges in extending dental care services to children and adults who need them.

1 Oral Health America. *Keep America Smiling: Oral Health in America.* The Oral Health America National Grading Project, 2003. Chicago, IL. http://www.oralhealthamerica.org/OralHealthParity.html

2 http://www.oralhealthkansas.org/pdfs/Kansas_Oral_Health_Plan.pdf.

Strategies to Improve Oral Health Care[3]

Prevention

- Expand oral disease prevention measures, especially school-linked oral health programs, use of fluoride varnish and dental sealants, and community water fluoridation
- Educate those in a position to stop the cycle of oral disease, including pregnant women, parents of young children, and caregivers of vulnerable populations
- Promote healthy childhood nutrition, especially pre-school and school nutrition programs
- Reduce tobacco use

Access to Care

- Expand Adult Medicaid to include dental coverage
- Increase the Medicaid dental provider network
- Increase Medicaid dental reimbursement rates
- Promote oral health as part of health reform initiatives at both the state and federal levels
- Target older adults and individuals with special needs with programming that offers enhanced oral disease prevention and treatment measures
- Support and sustain the development of regional safety net dental hubs

Workforce

- Invest in dental workforce expansion for underserved areas and vulnerable populations through workforce development initiatives such as the Advanced Education in General Dentistry (AEGD) clinical residency program, other expanded dental residency opportunities, and the use of Extended Care Permits (ECP) for dental hygienists
- Create a comprehensive workforce package, considering strategies such as loan repayment, a recruitment center, community incentive programs, and a pipeline project

Oral Health Leadership

- Collaborate with medical professionals and other healthcare providers to integrate oral health care, including fluoride varnish application, with general health promotion strategies
- Develop a diverse statewide network of Dental Champions that promote oral health through community, regional, and statewide initiatives

3 Visit http://www.oralhealthkansas.org for more information about the Oral Health Kansas's oral health policy agenda.

4 Oral Health America and the Center for Social Development and Education at the University of Massachusetts, Boston. *2007 National Oral Health Survey.* Oral Health America, Chicago, IL..

The majority of the American public consider oral health to be an essential part of overall health.[4]

Methodology

Oral Health America gathered public health information from a variety of sources to create an overview of oral health in Kansas, using the most recent primary data sources. Additional information was collected through conversations with the State's Office of Oral Health and Oral Health Kansas.

It should be noted that gaps in oral health data pose a great challenge to any assessment of oral heath status on a state-by-state basis. A commitment to ending oral health disparities throughout the country must include the ability to track the effects and progress of public health interventions for target populations.

GRADING SCALE	
A	4.00
B+	3.33 - 3.99
B	3.00 - 3.32
B-	2.67 - 2.99
C+	2.33 - 2.66
C	2.00 - 2.32
C-	1.67 - 1.99
D+	1.33 - 1.66
D	1.00 - 1.32
D-	0.67 - 0.99
F	0.00 - 0.66

Oral Health America based grading scales for each category on desired levels of oral health status and the availability and use of oral health services according to a variety of sources. These include the Healthy People 2010[5] goals, infrastructure recommendations from the Association of State and Territorial Dental Directors,[6] and conversations with numerous experts in a range of fields. In some categories, where desired levels have not been identified, Oral Health America developed grading scales based upon the national mean. The grading scales in this report are the same as those used in Oral Health America's 2003 report card for the nation, ***Keep America Smiling: Oral Health in America***.

Extra Credit

Kansas's hard work over the past five years is paying off with new focus from state legislators, foundation support for oral health programs, and recognition that oral health is critical to overall health. **Oral Health America is awarding the state an extra credit "A" grade for four recent successes that are changing the oral health landscape in Kansas, bringing the state's overall grade from a "C" to a "B".**

5 U.S. Department of Health and Human Services (USD-HHS), Healthy People 2010 (Conference Edition, in two volumes), Washington; January 2000.

6 Association of State and Territorial Dental Directors (ASTDD), Building Infrastructure & Capacity in State and Territorial Oral Health Programs, April 2001 (http://www.astdd.org).

In 2003, as Oral Health Kansas was being formed, the U.S. Surgeon General released ***A National Call to Action to Promote Oral Health***,[7] which outlines five action steps for improving oral health. They are:

1. **Change perceptions of oral health**
2. **Overcome barriers by replicating effective programs and proven efforts**
3. **Build the science base and accelerate science transfer**
4. **Increase oral health workforce diversity, capacity and flexibility**
5. **Increase collaborations**

The following successes were chosen for "extra credit" based on their state-wide impact on populations without routine access to dental care, and for addressing strategies identified by the Surgeon General's *Call to Action.*

It should be noted that these success stories stem from consensus within the state on how to address challenges that are in and of themselves not unique to Kansas. It is particularly heartening to see that Kansas has the resolve to not only identify solutions, but implement them.

EXTRA CREDIT SUCCESS STORY #1: Oral Health Kansas[8]

With a mission to increase oral health through advocacy, public awareness, and education, Oral Health Kansas, Inc., represents a broad base of supporters from widely diverse backgrounds from around the state. Launched in 2003, Oral Health Kansas is dedicated to influencing policy changes that will improve the oral health status of all Kansans. The organization's key efforts target policymakers at the local, state and federal levels—and the constituents who influence them.

Oral Health Kansas's turnkey programs include the "Dental Champions" leadership training program that develops state level leaders to advance a progressive oral health vision; a program to expand the utilization of the new Extended Care Permit for dental hygienists; the Tools for Schools oral health guidelines; and proactive strategies to engage the media on oral health issues. A new grant to Oral Health Kansas from the Developmental Disabilities Council enables the organization to arrange training of dental professionals in treating populations with developmental disabilities, and assist consumers in utilizing the Medicaid dental services available to them. Oral Health Kansas's public policy agenda includes expansion of adult Medicaid dental benefits, increased reimbursement rates, and strategies to expand the Medicaid dental provider network.

***National Call to Action* steps addressed:** change perceptions of oral health; overcome barriers by replicating effective programs and proven efforts; build the science base and accelerate science transfer; increase oral health workforce diversity, capacity, and flexibility; and increase collaborations.

7 U.S. Department of Health and Human Services, A National Call to Action to Promote Oral Health. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention and the National Institutes of Health, National Institute of Dental and Craniofacial Research, NIH Publication No. 03-5303, May 2003 (http://www.surgeongeneral.gov/topics/oralhealth/).

8 http://www.oralhealthkansas.org

EXTRA CREDIT SUCCESS STORY #2: Adult Medicaid Dental Benefit Waiver Expansions

In 2006, Kansas expanded adult Medicaid dental benefits for specific populations with special care needs and frail elders enrolled in Home and Community Based Services (HCBS) waiver programs. The Medicaid program now provides comprehensive oral health services, as determined by an oral health professional, for HCBS waiver enrolled frail elders, and adults with mental retardation, developmental disabilities, physical disabilities and traumatic brain injury.

While it is commendable that Kansas should expand dental benefits, it should be noted that Medicaid-eligible populations (approximately 75,000 adults) not covered by these waivers are limited to emergency procedures only. Moreover, those eligible for waiver programs may encounter long waiting lists to become enrolled in the program.

***National Call to Action* steps addressed:** change perceptions of oral health; overcome barriers by replicating effective programs and proven efforts.

EXTRA CREDIT SUCCESS STORY #3: Extended Care Permit

In 2003, Kansas created an Extended Care Permit (ECP), which allows registered dental hygienists to provide screening, education, and preventive dental hygiene services in certain community-based sites under the sponsorship of a dentist. The first sites included schools, local health departments, indigent health clinics, nursing homes, correctional facilities, and Head Start centers.

In 2007, the Kansas legislature broadened the law by increasing the number of community-based sites where ECP hygienists can provide services, including senior centers and senior meals sites, after school and community-based youth programs, and individual and group homes for the developmentally disabled, and youth in foster care. The new law also allows ECP hygienists to apply fluoride varnish and use topical anesthetic when working in the community.

Approximately 84 registered dental hygienists have completed the required training and have applied for an ECP. Several of these hygienists are now partnering with ECP sites, including safety net clinics that are utilizing an evolving "hub and spoke" model of service delivery. In this model, the ECP hygienist provides preventive care in the community and refers the patient back to the safety net clinic dentist for treatment.

Oral Health Kansas is providing ongoing training and technical assistance to current and new ECP hygienists and community sites that want to increase access to preventive dental services.

***National Call to Action* steps addressed:** change perceptions of oral health; increase oral health workforce diversity, capacity, and flexibility; increase collaborations.

EXTRA CREDIT SUCCESS STORY #4: Dental Hub Program

In a significant and promising new effort to increase access to dental care for Kansans without insurance and financial resources, private funders and state legislators have invested $5,262,000 in a "dental hub" concept promoted by the Kansas Association for the Medically Underserved (KAMU), Kansas's State Primary Care Association, and Oral Health Kansas to create a series of regional hubs operated by safety net clinics. The dental hubs are in central underserved locations, with spokes of care radiating out to satellite sites. The hubs focus on providing preventive, emergency, and restorative dental services to populations who are underserved by traditional dental care delivery systems. The "spokes" provide services in other areas of the region, for example via an ECP dental hygienist traveling to communities, nursing homes, or schools. The Kansas Oral Health Plan calls for the ongoing expansion of hubs and assurance that they are adequately staffed with dentists and dental hygienists.

***National Call to Action* steps addressed:** change perceptions of oral health; overcome barriers by replicating effective programs and proven efforts; increase oral health workforce, diversity, capacity, and flexibility; increase collaborations.

Mandy's Story: The Value of Oral Health

Mandy spoke with her hand in front of her mouth.

"It is hard to get a job. Nobody will hire me to work with customers," she said.

Rather than be seen in public, she worked cleaning the home of an older neighbor- which barely supported her and her son. She was embarrassed to speak, to eat in public, or go out much. Her son did not want her to meet his teachers because he was ashamed of her appearance.

For years, Mandy and her son received medical care at Southwest Boulevard Family Health Care in Kansas City, but the clinic had very little to offer for her dental needs. Because of her very low income, she postponed dental care.

In 2007, with the help of Delta Dental of Kansas, A-dec, and the REACH Foundation, Family Health Care opened a dental clinic, and recruited more than twenty volunteer dentists and dental hygienists to provide comprehensive dental care. Mandy's treatment plan at the new clinic included root canals, tooth restoration, and the placement of crowns and bridges. Family Health Care helped Mandy by restoring her health, the function of her teeth, and her appearance.

Mandy started attending parent-teacher conferences and her son's school work improved. In just a few months, with newfound confidence, she completed training as a nurse's aid and has a new job.

The difficulties that Mandy faced due to the pain, embarrassment, and poor health associated with significant dental disease are not unique, but her circumstances differ from most adults in similar situations in that she was able to access the care that she so desperately needed.

Report Card Categories, Grading Scales, and Data Sources

Dental caries (tooth decay) is an infectious, communicable disease that is almost entirely preventable.

One out of three Kansans on public water systems do not receive fluoridated water.[9]

PREVENTION

On-going disease prevention strategies that save long-term health costs, including the fluoridation of public water supplies and school-based or school-linked sealant programs, are safe, cost-effective, and prevent dental caries (an infectious, communicable disease that leads to cavities or tooth decay). For all families, but especially those with lower incomes, populations with special care needs, adults and children without routine dental care, pregnant women, and individuals who are at highest risk for oral health problems, oral disease prevention services are a vital component to overall healthcare. **Kansas earns a "C" for prevention.**

Fluoridation

FLUORIDATION	
A	88 - 100%
B	75 - 87%
C	**62 - 74%**
D	50 - 61%
F	0 - 49%

Community water fluoridation was introduced over 60 years ago, but 100 million Americans still do not have adequate fluoride in their drinking water. Fluoride reduces the incidence of tooth decay and slows or reverses the progression of existing caries lesions which lead to cavities.[10] Older adults and children without regular access to oral health care benefit greatly from fluoridated water. For this category, grades are based on the percentage of the population served by public water supplies receiving fluoridated water. **Only about 62 percent of the population on public water systems is receiving fluoridated water in Kansas,[11] earning the state a "C."**

School-based or school-linked Dental Sealant Programs

Dental sealants are among the most cost-effective and under-utilized means of protecting children's teeth from decay. Currently, 30 percent of children aged six to eleven years in the U.S. have dental sealants,[12] a plastic coating applied to the chewing surface of molar teeth.

9 Ibid, *Behavioral Risk Factor Surveillance Survey Data*.

10 Centers for Disease Control and Prevention (CDC), Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States, Morbidity and Mortality Weekly Report. 2001;50:1-42 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm).

11 Association of State and Territorial Dental Directors (ASTDD) Synopsis Questionnaire 2007, Kansas response.

12 Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. Trends in oral health status: United States, 1988-1994 and 1999-2004. National Center for Health Statistics. Vital Health Stat 11(248). 2007.

13 Kimminau K, Greiner A, The University of Kansas School of Medicine & Kansas Department of Health and Environment, *Smiles Across Kansas: 2007 Update.* (http://www.oralhealthkansas.org/pdfs/Smiles%20Across%20KS%202007.pdf)

In Kansas, 36 percent of third grade children have dental sealants.[13] The prevalence is far lower for children who may have higher decay risk: less than 10 percent of low-income, minority children in the U.S. have received a dental sealant.

Two key components of a strong dental sealant program are effective data collection, and a sustainable program model that reaches a significant percentage of children at risk for dental caries. Unfortunately, sealant prevalence data collected by states are not standardized, and Kansas does not follow the model for data collection recognized by previous report cards. The state operates only one sealant program in Emporia, while encouraging communities, schools, and ECP dental hygienists to develop and sustain school sealant programs at the local level. The number of children served by these programs are difficult to quantify. Although Oral Health America is unable to grade the state on its dental sealant programs, this category is too important to remove from the report, resulting in an "NA" or "not assessable" designation. The placement of dental sealants on children's teeth can help save money in restorative costs in the future.[14]

U.S. systemic and oral health care financing, policy, and delivery systems are disconnected and unequal, generally treating the mouth as separate from and independent of the body.[15]

Partnerships in Dental Medicine: The Value of Outreach and Collaboration

The Kansas Chapter of the American Academy of Pediatricians (KAAP) has made it a priority to promote early dental interventions in medical facilities. KAAP's on-line training program called "Bright Smiles for Kansas Kids," educates pediatric providers on fluoride varnish application for children up to three years of age. Through a program administered through the Kansas Department of Health and Environment's (KDHE) Office of Oral Health, dental hygienists support this effort by with in-person trainings and the delivery of a "toolkit" with 50 applications of fluoride varnish and coding reimbursement information. This collaboration between KDHE and KAAP is actively helping to promote the integration of oral health into physician's offices.

ACCESS TO DENTAL CARE

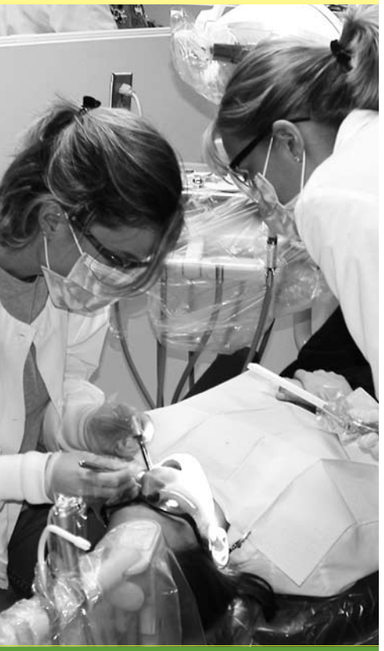
Millions of Americans are unable to get the oral health care they need because they do not have dental insurance (public or private), cannot pay out-of-pocket, and/or cannot find a provider who will treat them. Many regions of the country have a shortage of dentists, and most dentists do not participate in Medicaid. Medicare does not offer dental coverage, and states are not mandated to offer Medicaid dental benefits. Failing to help those without dental care can lead to high costs for invasive emergency procedures, and systemic illness. **Kansas earns a "D-" for access to care based on the availability of dental care providers.**

Only 36 percent of third grade children in Kansas have dental sealants.[16]

14 Snyder A, Gehshan S, *Kansas Health Reform: Options for Adding Dental Benefits*, National Academy for State Health Policy, September 2007 (http://www.oralhealthkansas.org/pdfs/NASHP-Full_Report.pdf).

15 Fisher-Owens S, Barker J, Adams S, Chung L, Gansky S, Hyde S, Weintraub J, Giving Policy some Teeth: Routes to Reducing Disparities in Oral Health, Health Affairs 27, no.2 (2008): 404-412, 10.1377/hlthaff.27.2.404.

16 Kimminau K, Greiner A, The University of Kansas School of Medicine & Kansas Department of Health and Environment, *Smiles Across Kansas: 2007 Update* (http://www.oralhealthkansas.org/pdfs/Smiles%20Across%20KS%202007.pdf).



Most counties in Kansas are designated as Dental Health Professional Shortage Areas (HPSA).[17]

It should be noted that the "dental hub" concept (*see page 7*) is actively expanding oral health access to underserved communities, and Oral Health America anticipates that this model is one that other states will replicate, including the notable provision of support from public and private funders. Future report cards would undoubtedly show progress for Kansas in access to care.

Availability of Dentists

An adequate supply of dentists is one factor in ensuring access to oral health care. Available national data reflect shortages of dentists, particularly in rural and inner-city areas. Practice patterns in Kansas reflect those trends, showing that dental practices are clustered in and around population centers. Almost 74 percent of respondents to a Kansas dentist survey reported practicing in one of five metro areas.[18] **Kansas earns a "D" grade overall for the availability of dentists as outlined in the categories below.**

Availability of Dentists

Grades are based on the number of professionally active, licensed general dentists in Kansas[19] compared to the state population.[20] **Kansas earns a "D" for its ratio of one dentist for every 2,476 individuals.**

AVAILABILITY OF DENTISTS		
A	1 dentist:	1 - 1,500 patients
B	1 dentist:	1,501 - 2,000 patients
C	1 dentist:	2,001 - 2,300 patients
D	**1 dentist:**	**2,301 - 2,600 patients**
F	1 dentist:	2,601+ patients

Availability of Pediatric Dentists

Only three percent of Kansas dentists are pediatric dentists, limiting access to care particularly for low-income children with poor oral health. Kansas has 32 pediatric dentists.[21] Given that most children under the age of one do not see a dentist, and that many children receive care from a general dentist, Oral Health America estimates that one third of the child population under age six may need access to a pediatric dentist. **Kansas's grade is a "D" for an estimated ratio of one pediatric dentist for every 2,363 children[22] under six who may need care**, though this grade does not show how the pediatric dentists are distributed throughout the state, affecting access to care.

AVAILABILITY OF PEDIATRIC DENTISTS		
A	1 dentist:	1 - 1,500 patients
B	1 dentist:	1,501 - 2,000 patients
C	1 dentist:	2,001 - 2,300 patients
D	1 dentist:	2,301 - 2,600 patients
F	**1 dentist:**	**2,601+ patients**

Percentage of Counties Without a Dentist

This category provides a cursory glance at workforce gaps at the state level. **Thirteen percent (fourteen out of 105) of counties in Kansas do not have a dentist,[23] resulting in a "D" grade.**

PERCENTAGE OF COUNTIES WITHOUT A DENTIST	
A	0%
B	1 - 5%
C	**6 - 10%**
D	11 - 15%
F	16% or more

Medicaid Providers

Efforts to increase dentist participation in Medicaid have had some success in a handful of states, but the majority of dentists in the country do not provide care to Medicaid patients. Kansas is addressing this issue by contracting with a Medicaid dental program administrator, EDS, which is actively recruiting dentists. In addition, Oral Health Kansas's public policy agenda includes an objective to support an increase in Medicaid fees, which are, on average, 48 percent of usual and customary rates. **Despite recent steps to improve dental access under Medicaid, Kansas earns a "D-" overall, based on the percentage of dentists who are Medicaid providers and "significant" Medicaid providers as outlined as follows.** Oral Health America believes that Kansas's strategies will pay off in the future and applauds the state's expansion of dental benefits to adult populations on Medicaid (*see page 6*).

Medicaid Dental Providers

Grades for this category are based on the percentage of general dentists in Kansas (32 percent)[24] who are enrolled as Medicaid billing providers with at least one paid claim. It should be noted that this category is not capable of revealing how active dentists are in the Medicaid program above and beyond one annual billing. **Kansas' grade is a "D".**

MEDICAID DENTAL PROVIDERS	
A	Over 70%
B	51 - 70%
C	36 - 50%
D	**21 - 35%**
F	20% or less

"Significant" Medicaid Dental Providers

"Significant" Medicaid dental providers are those who have integrated Medicaid recipients into their practices at somewhat higher levels than other dentists. Grades are

17 Dental HPSA Map, http://www.kdheks.gov/olrh/download/DEhpsaMap.pdf, March 2008; http://bhpr.hrsa.gov/shortage/hpsaguidepc.htm#Dental%20survey, March 2007.

18 2007 Office of Oral Health Dental Workforce Survey, http://www.kdheks.gov/ohi/index.html

19 ASTDD Synopsis Questionnaire 2008, Kansas response; Kansas Office of Oral Health communication with the Kansas Dental Board (est. 1,081 dentists).

20 Population Division, U.S. Census Bureau, Table 1: Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007 (NST-EST1007-01), December 27, 2007 (http://www.census.gov).

21 Kansas Office of Oral Health communication with the Kansas Dental Board.

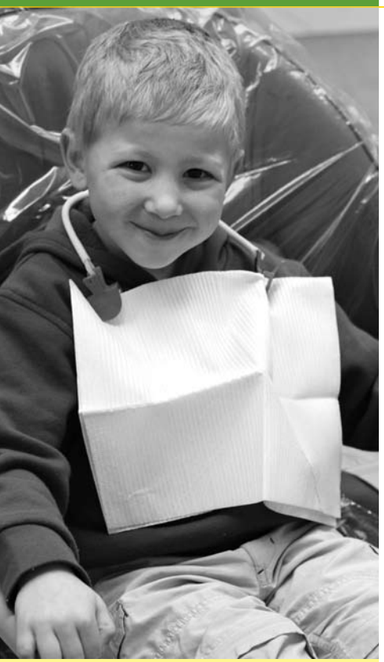
22 Number derived from 2000 Census Detailed Tables, Sex by Age data, http://www.census.gov

23 March 2008 HPSA map, http://www.kdheks.gov/olrh/download/DEhpsaMap.pdf.

24 Number of Medicaid billing providers compared to the number of dentists licensed by the state, ASTDD Synopsis Questionnaire 2008, Kansas response.

25 2007 Office of Oral Health Dental Workforce Survey (http://www.kdheks.gov/ohi/index.html).

An estimated 30 percent of dentists in Kansas plan to retire within the next ten years.[25]



based on the percentage of Medicaid billing providers in Kansas (14 percent)[26] with paid claims greater or equal to $10,000. Kansas's grade is a "D."

PERCENTAGE OF COUNTIES WITHOUT A MEDICAID DENTAL PROVIDER	
A	0%
B	1 - 5%
C	6 - 10%
D	11 - 15%
F	**16% or more**

Percentage of Counties without a Medicaid Dental Provider

Another approach to provide a general picture of the distribution of Medicaid providers is to look at the number of counties in a state that lack Medicaid-enrolled dentists. Grades are based on the percentage of counties in Kansas (20 percent)[27] without an enrolled Medicaid billing dentist. Kansas's grade is an "F."

"SIGNIFICANT" MEDICAID DENTAL PROVIDERS	
A	Over 50%
B	37 - 49%
C	23 - 36%
D	**13 - 22%**
F	12% or less

GraceMed Service Expansion: Community Support for Oral Health

New investments in South Central Kansas's GraceMed Health Clinic are expanding dental services to uninsured and underinsured families. The clinic was restarted in 2005 and has grown to ten dental operatories, and 15,864 patient encounters in 2007. In 2007, GraceMed also began providing dental hygiene care at preschools, parochial schools and senior adult residences, through dental hygienists with extended care permits (ECPs). GraceMed expects to add a third satellite clinic in Northeast Wichita this year, building on the "dental hub" concept. The clinic's growth has been dependent on the public/private collaborative relationship between area foundations, including the Sunflower Foundation, Delta Dental of Kansas Foundation, and United Methodist Health Ministries Foundation, private donors and the state and federal governments.

INFRASTRUCTURE

America's public health infrastructure plays a vital role in improving oral health. Oral Health America has identified the following categories to assess oral health infrastructure at the state level: leadership, oral health plan/input, and budget. Each of these categories are supported by the Healthy People 2010 Public Health Infrastructure Objectives. Kansas earns a "B+" grade for infrastructure.

26 ASTDD Synopsis Questionnaire 2008, Kansas response.
27 ASTDD Synopsis Questionnaire 2008, Kansas response.

Leadership

The presence of a full-time state dental director is one indication of state commitment to addressing oral health problems. Kansas gets an "A" for leadership.

Plan/Input

For having a state oral health plan,[28] and an active oral health coalition, Kansas earns an "A."

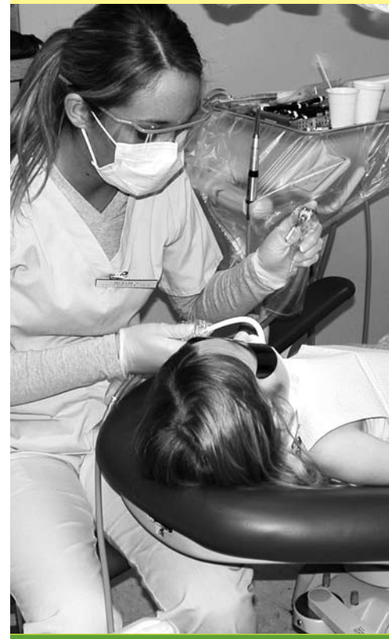
Oral Health Plan

A key element in successful oral health policy is the development and maintenance of a state oral health improvement plan that, through a collaborative process, selects appropriate strategies for target populations, establishes integrated interventions, and sets priorities for the state. Kansas gets an "A" for an excellent oral health plan, released in November 2007.

LEADERSHIP	
A	**The state dental director is full-time, and is an oral health professional with public health training.**
B	The state dental director is full-time, and is either an oral health professional or has public health training, but not both.
C	The full-time state dental director is not an oral health professional and has no public health training; or the dental director is part-time and has dental or public health training.
D	The state dental director is part-time and has no oral health or public health training.
F	No dental director.

ORAL HEALTH PLAN	
A	**The state has a long-term oral health improvement plan, developed through a collaborative process, with a broad range of constituents, and is reviewed regularly.**
B	The state oral health plan was developed through a collaborative process, with a broad range of constituents, but is not reviewed regularly; or the plan is reviewed regularly, and was developed collaboratively, but not with a broad range of constituents.
C	The state oral health plan was either developed collaboratively, or was developed with a broad range of constituents, or is reviewed regularly.
D	The state oral health program was not developed collaboratively, with a broad range of constituents, and is not reviewed regularly.
F	The state has no oral health plan.

28 http://www.oralhealthkansas.org/pdfs/Kansas_Oral_Health_Plan.pdf.
29 Ibid, *Smiles Across Kansas: 2007 Update.*
30 Kimminau K, Huang C, McGlasson D, Kim J, Kansas Health Institute & Kansas Department of Health and Environment, *Smiles Across Kansas 2004: The Oral Health of Kansas Children* (http://www.kdheks.gov/ohi/download/smiles_across_kansas_2004.pdf).



Approximately 21 percent of third grade children in Kansas had untreated tooth decay,[29] and more than 50 percent of all children have experienced tooth decay during their lives.[30]

People with disabilities are at greater risk for oral diseases and are less likely to be treated. Nationally, one of two people with a significant disability cannot find a professional resource to provide appropriate and necessary dental care.[31]

Oral Health Coalition

A working state oral health coalition can increase public awareness of oral diseases, leverage resources, broaden approaches to programming, enhance public policy and resource development, improve duplication and gaps in services, and add the time, energy and resources of individual members. Over 200 members strong, **Oral Health Kansas[32] is one of the most proactive, resourceful coalitions in the country, earning the state an "A."**

ORAL HEALTH COALITION	
A	**The state oral health coalition meets regularly and represents government agencies, health departments, private organizations, providers, communities and consumers.**
B	The state oral health coalition meets regularly, and represents government agencies, health departments, private organizations, providers, and either communities or consumers.
C	The state oral health coalition meets regularly, and represents government agencies, health departments, private organizations, and providers, but does not represent communities or consumers.
F	There is no oral health coalition.

Budget

Grades are based on whether or not the Kansas oral health budget adequately funds the infrastructure and capacity to plan, develop, and implement oral health programs. Oral Health America looked at three measures: budget size, past year budget changes, and state support for the oral health program budget in an attempt to gauge budget strengths and weaknesses. **Each of these factors contributes to Kansas's "B" grade.**

STATE ORAL HEALTH PROGRAM BUDGET SIZE	
A	$ .44 or more per person
B	$ .31 - .43 per person
C	$ .21 - 30 per person
D	**$ .11 - .20 per person**
F	$ .10 or less per person

State Oral Health Program Budget Size

Grades for this category are based on the averages of upper and lower budget estimates detailed for four model state oral health programs representing varying levels of resources and environments as identified by the Association of State and Territorial Dental Directors (ASTDD).[33] The numbers provided in the following grading scale are estimates of adequate funding levels, but are not intended to serve as target funding ranges. **Kansas earns a "C" grade for its oral health program budget size**, based on the size of the Office of Oral Health 2008 budget divided by the state population.[34] This category accounts for 50 percent of the overall budget grade.

State Oral Health Program Budget Changes

Kansas earns an "A" for a past year increase in the oral health budget,[35] accounting for 25 percent of the overall budget grade.

STATE ORAL HEALTH PROGRAM BUDGET CHANGES	
A	**The oral health program budget increased significantly in the past year.**
B	The oral health program budget increased with inflation in the past year.
C	The oral health program budget stayed the same in the past year.
F	The oral health program budget decreased in the past year.

State Support for the Oral Health Program

Most programs are funded by federal block grant dollars, state dollars, or a combination of both. The presence of state funding indicates a greater level of commitment to oral health of state residents. **The Kansas dental director's position is funded through the Department of Health and Environment in the state's budget,[36] resulting in an "A" grade for this category,** which accounts for 25 percent of the overall budget grade. It should be noted however, that the state does not provide funding for the Office of Oral Health directly.

STATE SUPPORT FOR THE ORAL HEALTH PROGRAM	
A	**The state oral health program is supported by the state budget.**
F	The state oral health program is unsupported by the state budget.

The primary reason for Kansans not receiving the dental care they needed in the past year was cost.[37]

31 Fenton SJ, Universal Access: Are We Ready? (Editorial). *Special Care Dentistry* 1993; 13:94.
32 http://www.oralhealthkansas.org.
33 ASTDD, Building Infrastructure & Capacity in State and Territorial Oral Health Programs.
34 Source of budget information: ASTDD State Synopsis Questionnaire 2008, Kansas response; Population Division, U.S. Census Bureau, Table 1: Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007 (NST-EST1007-01), December 27, 2007 (http://www.census.gov).
35 Source of budget information: ASTDD State Synopsis Questionnaire 2008, Kansas response; communication with Kansas Office of Oral Health.
36 Source of budget information: ASTDD State Synopsis Questionnaire 2007, Kansas response.
37 BRFSS, 2006 State Added Module (http://kdheks.gov/brfss/index.html).

In the U.S., employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.[38]

HEALTH STATUS

In developing a picture of America's oral health status on a state-by-state level, one thing is clear: the U.S. is in need of additional data, comparable for all states, that tracks disease prevalence and health status for all ages. **Kansas earns a "C+" in this category,** as determined by the following, admittedly limited, oral health status indicators available.

Dental Status of Adults

This category measures the percentage of self-reported adults that have had any permanent teeth extracted due to decay or disease. **Approximately 41 percent of adults in Kansas have had any permanent teeth extracted,**[39] **for a "B" grade.**

Dental Status of Older Kansans

Grades are based on the percentage of self-reported people 65 and older, with no natural teeth. **Approximately 19 percent of older Kansans have had all of their natural teeth extracted,**[40] **for a "B" grade.**

DENTAL STATUS OF ADULTS	
A	Less than 33% of adults have had any permanent teeth extracted.
B	**33-42% of adults have had any permanent teeth extracted.**
C	43-52% of adults have had any permanent teeth extracted.
D	53-62% of adults have had any permanent teeth extracted.
F	63% or more of adults have had any permanent teeth extracted.

DENTAL STATUS OF OLDER KANSANS	
A	Less than 17% of adults aged 65 years and older have no natural teeth.
B	**17-24% of adults aged 65 years and older have no natural teeth.**
C	25-32% of adults, 65 and older, have no natural teeth.
D	33-41% of adults, 65 and older, have no natural teeth.
F	42% or more of adults 65 and older have no natural teeth.

Youth Tobacco Use

The use of tobacco products can lead to the development of numerous oral diseases, including oral and pharyngeal cancers, as well as periodontal disease, gum recession, tooth decay, and oral lesions. In addition, smokeless or "spit" tobacco use is strongly linked to soft tissue oral lesions in both young people and adults. **For levels of youth tobacco use, Kansas earns a "D+" grade.**

High School Cigarette Use

Grades are based on the percentage of high school students reporting cigarette use in the past 30 days. **Approximately 21 percent of high school students report cigarette use in the past 30 days,**[41] **for a "C" grade.**

High School Male Smokeless Tobacco Use

Grades are based on the percentage of high school males reporting smokeless or "spit" tobacco use in the past 30 days. **Approximately 17 percent of high school males report smokeless tobacco use in the past 30 days,**[42] **for a "D" grade.**

HIGH SCHOOL CIGARETTE USE	
A	0%
B	1 - 16%
C	**17 - 25%**
D	26 - 35%
F	36% or more

HIGH SCHOOL MALE SMOKELESS TOBACCO USE	
A	0%
B	1 - 7%
C	8 - 14%
D	**15 - 20%**
F	21% or more

POLICIES

Fluoridation Laws

States with strong community fluoridation laws are in a better position to support the maintenance and upkeep of aging water systems and encourage communities to adopt fluoridation as a measure that will benefit all residents. **Kansas has no law intending to provide community water fluoridation, for a "D" grade.**

FLUORIDATION LAWS	
A	A state law exists that intends to provide statewide fluoridation. The state mandates fluoridation for all communities except where natural fluoridation occurs.
B	A state law exists that intends to provide statewide fluoridation, and a significant percentage of the population on community water supplies receives fluoridated water. Limited exclusions exist within the law.
C	The state has a fluoridation law, but there are attached conditions that provide barriers to the state's ability to fluoridate.
D	**There is no law intending to provide statewide fluoridation.**
F	Laws exist that impede community water fluoridation.

Competitive Food Policies

Healthy food choices and good oral health go hand in hand. Obesity rates are skyrocketing, and over half of adolescents in the U.S. have experienced tooth decay by

Kansas over age sixty-five are most likely to lack dental insurance of any age group.[43]

38 Ibid, *Oral Health in America: A Report of the Surgeon General.*
39 Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), 2006.
40 Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), 2006.
41 Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS), 2005.
42 Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS), 2005.
43 http://www2.kumc.edu/kcr/PDF-Files/2004/Cancer2000-2004.pdf.

Children lose more than 51 million school hours each year to dental-related illness.[44]

COMPETITIVE FOOD POLICIES	
A	Comprehensive nutrition standards for all foods sold outside the USDA meal programs, anywhere on campus, throughout the school day.
B	Minimal nutritional standards set for foods sold outside the USDA meal programs, anywhere on campus, throughout the school day.
C	Limit sales of foods of minimum nutritional value anywhere on campus up until the last lunch period is over.
D	**USDA Regulations only; additional regulations only relate to who makes the money from the sale of competitive foods.**

their senior year in high school. The U. S. Department of Agriculture has established policies, which all states follow, to control the sale of foods sold in competition with school meal programs. However, these policies provide few restrictions—presenting an opportunity for states and school food authorities to place additional restrictions on the sale of competitive foods. **Kansas can establish clear guidelines on the sale of foods of little nutritional value in schools, including soda and sugary, high-carbohydrate foods and improve its "D" grade.** Grades are based on Kansas's competitive foods policies[45] above and beyond USDA regulations.

State Tobacco Excise Taxes

Numerous studies show that increasing tobacco excise taxes is one of the most effective ways to reduce tobacco use among youth and adults, but Kansas has not increased these taxes in more than four years. Higher taxes make tobacco products more expensive, keeping young people from using products. For this category, Oral Health America reviewed existing excise taxes for cigarettes and smokeless tobacco products as an indication of the state's commitment to enacting and enforcing laws that can reduce the number of young people who use tobacco products. Kansas earns a "D" for comparatively low tobacco excise taxes.

CIGARETTE EXCISE TAXES	
A	$1.25 or more per pack
B	$.93–$.124 per pack
C	**$.64–$.92 per pack**
D	$.36–$.63 per pack
F	$.35 or less per pack

Cigarette Excise Taxes

Kansas taxes cigarettes at $.79 per pack,[46] an amount that has not changed as many other states increase cigarette taxes. Ranked 19th for cigarette tax in 2003 by the Campaign for Tobacco-Free Kids, Kansas is now 31st. **Kansas earns a "C" grade in this category.** Grades are based on a scale developed for the American Lung Association's *State of Tobacco Control: 2002*.[47]

Smokeless Tobacco Excise Taxes

Grades are based on moist snuff taxes in each state. **Kansas has one of the lowest smokeless tobacco taxes in the country—10 percent of wholesale manufacturer's price,[48] earning the state an "F" grade.**

SMOKELESS TOBACCO EXCISE TAXES	
A	90% or more of wholesale or manufacturer's price
B	65-89% of wholesale or manufacturer's price
C	40-64% of wholesale or manufacturer's price
D	20-39% of wholesale or manufacturer's price
F	**Less than 20% of wholesale or manufacturer's price**

Adult Medicaid Dental Policies

Current Medicaid law allows for states, at their own discretion, to provide dental services for adults—or not. Kansas provides comprehensive oral health services for frail elderly, and adults with mental retardation, developmental disabilities, physical disabilities and traumatic brain injury enrolled in the HCBS waiver programs. Medicaid-eligible populations (approximately 75,000 adults) not covered by these waivers are limited to emergency-only coverage, meaning that those who need care likely end up in the emergency room, where treatment can be costly and invasive. Grades are based on the level of oral health services provided through Medicaid. **Kansas earns a "C" for expanding Medicaid dental benefits for populations with special care needs**, but still falls well short of a "B" or "A" grade.

ADULT MEDICAID DENTAL POLICIES	
A	The state Medicaid program has full adult dental benefits, including preventive services.
B	Medicaid adult dental benefits are fairly comprehensive, with the exception of some services.
C	**The Medicaid program provides partial adult dental services.**
D	The state Medicaid program covers tooth extractions and emergency adult dental services only.
F	The state Medicaid program covers no adult dental benefits.

Medicare provides no routine dental benefits. Medicaid dental benefits are optional for states. In Kansas, a limited number of adults with special care needs and frail elders have full dental benefits. Dental benefits for most adults on Medicaid are limited to emergency services.[49]

44 Ibid, *Oral Health in America: A Report of the Surgeon General.*

45 Communication with the Kansas Office of Oral Health; United States Department of Agriculture (USDA) State Competitive Foods Policies 2002.

46 Campaign for Tobacco Free Kids, Key State-Specific Tobacco-Related Data & Rankings, June 21, 2007 (www.tobaccofreekids.org/research/factsheets).

47 American Lung Association. State of Tobacco Control: 2002 (http://lungaction.org/reports/tobacco-control.html).

48 Campaign for Tobacco Free Kids, State Excise Tax Rates for Non-Cigarette Tobacco Products, March 12, 2002. www.tobaccofreekids.org/research/factsheets/pdf/0169.pdf

49 Office of Oral Health, Kansas Department of Health and Environment & Oral Health Kansas, *Kansas Oral Health Plan*, Topeka, KS, November 2007 (http://www.oralhealthkansas.org/pdfs/Kansas_Oral_Health_Plan.pdf).39
Source of budget information: ASTDD State Synopsis Questionnaire 2007, Kansas response

Grades

KANSAS'S OVERALL ORAL HEALTH GRADES - 2009

Prevention	**C**	Fluoridation	**C**		
		Sealant Program Overall	**NA**		
Access	**D-**	Dentist Availability	**D**	Dentist Availability	**D**
				Pediatric Dentist Availability	**D**
				Percent of Counties Without a Dentist	**D**
		Medicaid Providers	**D-**	Percent of Counties Without a Medicaid Dental Provider	**F**
				Medicaid Dental Providers	**D**
				Significant Medicaid Dental Providers	**D**
Infrastructure	**B+**	Leadership	**A**		
		Oral Health Plan/Input	**A**	Oral Health Plan (.50)	**A**
				Oral Health Coalition (.50)	**A**
		Oral Health Budget	**B**	Budget Size (.50)	**C**
				Budget Change(.25)	**A**
				State Support for Oral Health Budget (.25)	**A**
Health Status	**C+**	Adults w/6 or more teeth removed due to decay/disease	**B**		
		Edentulous Elderly	**B**		
		Youth Tobacco Use	**D+**	High School Cigarette Use	**C**
				High School Male Smokeless Tobacco Use	**D**
Policies	**D**	Fluoridation Laws	**D**		
		Competitive Food Policies	**D**		
		Tobaco Excise Taxes	**D**	Cigarette Excise Taxes	**C**
				Smokeless Tobacco Excise Taxes	**F**
Extra Credit	**A**				
FINAL GRADE	**B**				

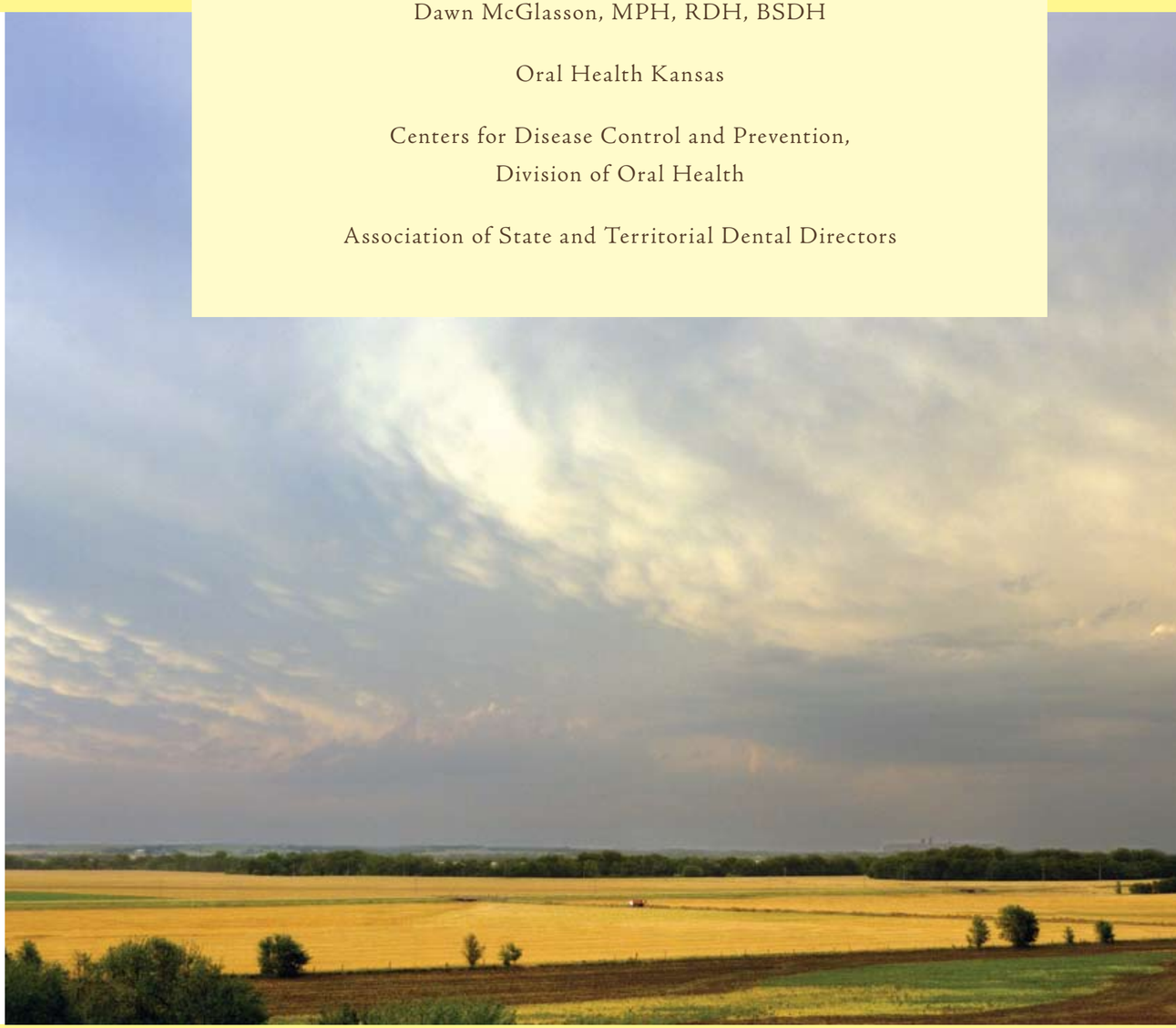
Acknowledgements

Dawn McGlasson, MPH, RDH, BSDH

Oral Health Kansas

Centers for Disease Control and Prevention,
Division of Oral Health

Association of State and Territorial Dental Directors



Author: Elizabeth Rogers, Director of Communications, Oral Health America

Graphic Design: Arielle Walrath

Photography:
Front Cover Steve Mulligan
Inside Front Cover George Jerkovich
This page George Jerkovich

Oral Health America is working to eliminate oral disease by connecting people to resources, empowering communities, and influencing public policies and practices.

ORAL HEALTH AMERICA
LEADING THE WAY TO A HEALTHY FUTURE

Oral Health America
410 N. Michigan Avenue, Suite 352
Chicago, IL 60611
Phone 312-836-9900
Fax 312-836-9900
www.oralhealthamerica.org

Campaign for Oral Health Parity